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Hospital Nurse Competency to Care for Patients With Behavioral Health Concerns

A Follow-Up Study

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Nonpsychiatric nurses care for hospital patients with behavioral health (BH) conditions. This study found BH care competencies of hospital nurses slightly changed from those 9 years earlier. On average, nurses reported moderate to strong perceived competence about assessing/intervening and accessing resources to care for BH patients. They perceived less competence in recommending psychotropic drugs for patients who may need them. Staff development programs that aim to enhance nurse BH care competencies are needed.

Given the prevalence of comorbid psychiatric conditions in patients cared for in nonbehavioral health settings (Janssen et al., 2015), nurses encounter patient care situations demanding particular competencies (Beks et al., 2018; Giandinoto & Edward, 2014). Poor competence can lead to poor care experiences (Digby et al., 2017; Zolnieriek & Clingerman, 2012) and increased safety risks for nurses and patients (Dolan & Looby, 2017; Speroni et al., 2014; Wyatt et al., 2016). Perceived

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competencies of nonpsychiatric nurses in dealing with behavioral health (BH) patients have been documented using scales such as the Behavioral Health Care Competency questionnaire (Marine, 2018; Rutledge et al., 2012) and others (Baker et al., 2019; Weare et al., 2019). Prior work has found that nurses working in emergency care perceive themselves more competent than those in other nonpsychiatric areas (Bredimus, 2020; Rutledge et al., 2013) and that educational efforts can enhance perceived competence (Baker et al., 2019; Bird, 2018; Bredimus, 2020; Elvish et al., 2018; Winokur et al., 2017).

BACKGROUND

At our southwestern Magnet-accredited community hospital with an inpatient psychiatry unit, nonpsychiatric clinical nurse BH care competency was assessed as part of a 2011 multisite study (Rutledge et al., 2013) with no follow-up evaluation. Since 2011, initiatives taken in various care areas at the hospital may have impacted nurse perceived competency.

Changes to the hospital care delivery model for BH patients occurred when a psychiatric hospitalist team began providing services in 2017. The team, composed of two psychiatrists specializing in emergency psychiatry and addiction medicine, several psychiatric mental health nurse practitioners, and staff psychologists, evaluates and begins treatment of emergency care center (ECC) patients and provides initial assessment and consultation for patients hospitalized within the acute care hospital.

Education has been targeted to specific areas. Women's services registered nurses had concentrated nonmandatory in-person education on neonatal abstinence syndrome and were offered education on substance use for perinatal patients (2019). The medical-surgical, telemetry, and ECC new graduate residencies now include 4 hours of in-person instruction on caring for BH patients. The ECC has offered in-person programs on BH and substance abuse assessment/care after the addition of a 12-bed psychiatric holding area within emergency services. As a result, 30%–40% of the ECC annual medication test relates

to psychiatric medications. Specific in-person offerings for ECC nurses and staff included the following: 2014: Care of the Psychiatric Patient in the Emergency Department (4 hours); 2015: Care of the Patient With Suicide Ideation, Drugs of Abuse, and Use of Standardized Treatment Protocol to Educate Patients (3 hours); 2016: Care of Patients With Serious Mental Illness and Comorbid Medical Conditions (2 hours); 2017: Substance Abuse, Motivational Interviewing, and Care of the Patient with Autism (2 hours) and Care of Homeless Patients With Behavioral Health and Substance Abuse Issues (2 hours); 2018: Violence Recognition, Personal Safety, and Proactive Management of Patients (1.5 hours). The 2014 offering was done during annual skills days, with an estimated 95% completion rate for ECC nurses. The other classes were nonmandatory, and it is unknown what percentage of nurses attended.

Despite this work, in the 2019 Educational Needs Assessment (Clinical Essentials Category), half or more of clinical nurses rated care of the BH patient (56%) and BH treatment modalities (50%) among their top educational needs, whereas 63% of nurse managers identified BH treatment modalities as their greatest need. These assessments included nurses who worked in our psychiatric unit. As part of planning future educational and skill-building activities, we surveyed nonpsychiatric nurses—including those in nonclinical roles—to describe their current competencies related to caring for patients in non-BH settings who have BH issues.

METHODS

This cross-sectional survey of nurses received exempt status from the health system institutional review board. This article describes baseline perceived competencies of nurses surveyed July 2020 (during the coronavirus pandemic).

Sample/Setting

Nurses in all roles were eligible to participate if they were regular hospital employees and not working in any psychiatric or chemical dependency area (for any employer). Excluded were traveling nurses and nurses from outside registries.

Measures

The survey included a set of demographic questions and the Behavioral Health Care Competency (BHCC) survey (Rutledge et al., 2012). Demographic items include nurse role (clinical nurse, other roles), work setting (e.g., ECC), gender, education, years worked in nursing and hours worked per week, number of nonbasic or advanced life support certifications (e.g., not Basic Life Support), psychiatric or chemical dependency experience (yes/no), management of assaultive behavior (MAB) training (yes/no), having experienced violence with a psychiatric patient (yes/no), and certification in a nursing specialty (yes/no).

Designed to measure hospital nurses' perceptions of their individual BH care competencies, the BHCC has

demonstrated content and construct validity (Rutledge et al., 2012). It consists of 23 items that use 5-point Likert-type scales (1 = *strongly disagree* to 5 = *strongly agree*). Four items (one from each subscale; italicized in results table) were worded such that they required reverse coding upon analysis. The four BHCC subscales demonstrated adequate internal consistency in this study: assessment (nine items, $\alpha = .85$), practice/intervention competency (eight items, $\alpha = .85$), recommendation of psychotropics (two items, $\alpha = .79$), and resource adequacy (four items, $\alpha = .69$). The total BHCC had an internal consistency coefficient of .91. The higher the score, the higher the respondent's perceived competency is.

Recruitment and Study Procedures

Nurses were invited to complete the survey through invitations to individual e-mails during July 2020 (during the coronavirus pandemic). Initial invitations were followed with two weekly e-mails. Nurse managers and clinical educators reminded nurses about the study during huddles and staff meetings. No incentives were used. Surveys were collected anonymously using SurveyMonkey software, which is General Data Protection Regulation compliant. Responses were received from 307 nurses (estimated 307/1,000 = ~31%): 91 in Week 1, 82 in Week 2, and 134 in Week 3.

Data Analysis

Data were described using descriptive statistics. Differences between groups (e.g., male/female, work settings, have prior psychiatric work history, different allied professional types) were done using analyses of variance or chi-square analyses (categorical data). Level of significance was set at .05.

RESULTS

Sample

Supplemental Digital Content 1 (see Supplemental Digital Content 1, <http://links.lww.com/JNPD/A55>) shows characteristics for the 307 nurses who completed at least part of the survey. Nurses were predominately women (91%); 68% had a baccalaureate or higher degree in nursing. Most were clinical nurses (69%), whereas fewer than 10% each were in specific leadership or nonstaff roles. They worked in multiple hospital areas: critical care/observation ($n = 25$, 8%), ECC ($n = 37$, 12%); medical/surgical including telemetry, oncology, and float pool ($n = 129$, 42%); surgical services including pre-post anesthesia units ($n = 14$, 5%); women's services ($n = 48$, 16%); other clinical areas (radiology, vascular access team, chronic dialysis; $n = 16$, 5%); and other areas (indirect support, other; $n = 37$, 12%).

In general, nurses were experienced, averaging 14.2 years in nursing (range: 0–50). They worked an average of 35.2 hours per week (range: 6–60). Few nurses had prior psychiatric or chemical dependency experience ($n = 56$, 18%),

whereas almost half ($n = 150$) reported having taken MAB training and 59% ($n = 181$) reported experiencing an incident of violence involving a psychiatric patient.

BHCC Results

The mean BHCC total score was 3.52 (see Supplemental Digital Content 2, <http://links.lww.com/JNPD/A56>), indicating moderately strong perceived competency in caring for BH patients. Total sample average subscale scores, from highest to lowest, were resource adequacy ($M = 4.0$, $SD = 0.6$), assessment ($M = 3.7$, $SD = 0.6$), practice/intervention competency ($M = 3.4$, $SD = 1.0$), and recommending psychotropics ($M = 2.4$, $SD = 0.6$). Thus, hospital nurses reported moderate to strong perceptions that they had or knew when to access resources to care for BH patients in their work units and that they could appropriately assess and intervene among patients with BH needs. On average, nurses perceived themselves less able to recommend psychotropic drugs to other providers for patients who may need them. As seen in Supplemental Digital Content 2 (see Supplemental Digital Content 2, <http://links.lww.com/JNPD/A56>), individual items with the lowest scores within each subscale were the ability to distinguish between delirium and dementia (50% of nurses agreed/strongly agreed), intervene with patients having hallucinations (38% agreed/strongly agreed), recommend psychotropic drugs to physicians for psychiatric patients (16% agreed/strongly agreed), and perceive hospital resources were available (62% agreed/strongly agreed).

No differences were found in BHCC subscale scores between clinical/staff nurses and nurses in other roles, between nurses who were certified and those not, and between nurses who worked nights and those who did not (one-way analyses of variance, $ps > .05$). As seen in Supplemental Digital Content 3 (see Supplemental Digital Content 3, <http://links.lww.com/JNPD/A57>), nurses who had prior psychiatric or chemical dependency experience, training in MAB, and prior experience with violence in a psychiatric patient had significantly higher perceived competence in assessment, practice/intervention, and recommending psychotropics; those with MAB training also had significantly higher perceived resource adequacy.

Significant differences in BHCC scores by work setting were found (see Supplemental Digital Content 4, <http://links.lww.com/JNPD/A58>). On all subscales and total BHCC scores, emergency nurses scored higher than nurses from other settings. Women's health nurses scored significantly lower than other groups (except for resource adequacy).

DISCUSSION

This is the first known study to evaluate changes over time in perceptions of BH competency among nurses working in a hospital that has made considerable efforts to enhance

nurse competency in this area. Study findings enable comparison of 2020 nurse perceptions of BH competency with those collected in 2011 (Rutledge et al., 2013). The earlier study was limited to clinical or staff nurses from three community hospitals (including that from the current study); scores did not differ by hospital and were reported in aggregate. The current study includes clinical/staff nurses as well as those in other roles; BHCC scores were not found to differ based upon role. In 2020 compared with 2011 (see Supplemental Digital Content 5, <http://links.lww.com/JNPD/A59>), nurses perceived themselves slightly more competent overall (total BHCC score) with similar scores about assessment competency, somewhat greater perceived competency related to practice and resource adequacy, and lower scores on recommending psychotropics. The earlier sample contained about 14% nurses from the emergency department whereas the current study contained 12%, so this probably was not a factor in the lower scores on recommending psychotropics.

Given hospital initiatives since 2011, the sample for this study reflects greater proportions of nurses with MAB training (49%) than prior work (34% for nurses from three hospitals; Rutledge et al., 2012), where having such training was found to enhance BH care competency. MAB training at the study hospital includes not only the required content as outlined in California State Health and Safety Code 1257.8 but also the identification of nonintentional sources of violence, hospital-specific policies related to aggression and violence, and the availability of resources for staff. In many hospitals, such training has been limited to psychiatric nurses, emergency nurses, and staff serving on behavioral emergency response teams (Pestka et al., 2012); study findings point to the need to extend this training to nurses in nonpsychiatric settings as it may enhance perceived competency.

Findings from our study support earlier findings that nurses who have experience with violence in psychiatric patients have higher perceived BH care competency (Rutledge et al., 2012). This may reflect the particular sample because nurses who work in areas where violence is more common (ECC, medical-surgical units admitting older patients who may experience dementia/delirium; Liu et al., 2019) have received MAB training (in this study, 81% of nurses with MAB training also reported violence exposure). However, in the 19% of nurses who had not received MAB training, the violence exposure may have triggered actions on the part of individual nurses to enhance their competency related to BH care. This is an area for future research.

This study expands the sample of the earlier study among hospital staff nurses (Rutledge et al., 2013) to nurses in other roles, including executive leadership, advanced practice nurses, and clinical educators. Our finding that clinical/staff nurse perceptions of BH care competency did not differ

from those of nurses in other roles adds to the literature on this topic. This indicates that nurses in all roles need interventions that help improve perceived competency.

The current study findings indicate only small increases in average perceived competence for hospital nurses despite multiple efforts (primarily in the ECC). A major implication is that professional staff development related to BH care competency among nonpsychiatric nurses requires multiple and ongoing efforts. Another implication is that nurses outside the emergency department, particularly those in women's services, may be particularly challenged and require targeted efforts. Changes in care delivery models and educational programs may not help nurses perceive they can adequately care for these often-challenging patients with BH issues (Munoz et al., 2021). Skill-building exercises necessary to truly change perceived competence may require resources that many hospitals do not have. Thus, making sure that nurses are aware of their resources and that these resources are available is necessary.

Our findings in hospital nurses indicate continuing deficits in perceived competency related to recommending psychotropics and dealing with specific BH issues (dementia/delirium, assaultive behavior). These same deficits were reported following an evaluation of an 8-hour Mental Health First Aid course as a means of providing registered nurses with training to improve basic BH competencies (Baker et al., 2019); specifically, nurses completing that course desired more information about medication use for acute episodes; deescalation; delirium and dementia; and dealing with assaultive, abusive, or combative patients.

The nursing process may be helpful in framing education for nurses who want to enhance their BH competency. Specific educational programs are available. The American Psychiatric Nurses Association has developed a 15-hour online program for new graduates and nurses transitioning into psychiatric nursing (Adams & Black, 2016); the certificate program covers content on therapeutic engagement, psychotherapeutics, and mental health and addiction disorders, among others. Mental Health First Aid is an 8-hour National Council for Behavioral Health-sponsored program that covers risk factors and warning signs of mental health problems, understanding of their impact, and common treatments (National Council for Behavioral Health, 2021); it is not specifically targeted to healthcare providers. There are few recently published evaluations of MAB programs (Cahill, 2008; Casey, 2019; Farrell & Salmon, 2009; Lee et al., 2017).

Limitations of this study are the convenience sample and the cross-sectional survey method. Strengths include the use of an existing survey tool, replication of an earlier study method, and the adequate response rate from nurses. With the replication, comparison of findings from earlier findings using the same method was possible, noting that the samples were different: The 2011 study sample

was clinical nurses from three "sister" hospitals; the 2020 sample included nurses in all roles working at a single hospital. Because we did not ask nurses in 2020 how long they worked at the hospital, we were unable to determine whether longevity at the hospital (and the likelihood of exposure to some of the hospital initiatives) may have impacted competency.

CONCLUSIONS

This study validates the need for targeted staff education related to caring for patients who have BH conditions. Findings support education for nurses in all roles and in work settings beyond the emergency department (where most such education may already be offered). MAB programs are given in many hospitals to nurses in specific areas, such as the emergency department, but may be useful to nurses outside these areas.

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